Report for Faculty Curriculum Committee on the Rural Medical Immersion Programme

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Background
The Rural Medical Immersion Programme (RMIP) was established in 2007. Since then it has expanded, and also undergone considerable internal upheaval with the death in 2009 of the inaugural director, Dr Pat Farry. In early 2011, the Faculty Curriculum Committee asked the Faculty Education Unit to coordinate a review of the programme. This was undertaken as an informal internal review, ahead of an official University Quality Assurance Unit review to be held in 2012.
Executive summary

There are three questions that the Faculty might wish to consider regarding a review.

1. Is the programme an appropriate and acceptable educational experience?
2. Does the programme represent good value for money?
3. Does the programme fulfil the aims for which it is designed, specifically the impact on the rural work force?

This internal informal review is focused on the educational experience provided. It does not consider ‘value for money’ or consider whether the programme fulfils the aims for which it was designed. Neither is it a comparison with campus-based Year 5 experiences.

A series of commendations and recommendations have been generated after discussion of RMIP documentation (hard copy and web based); staff feedback through interviews and surveys; student feedback through focus groups.

The primary educational aim of RIMP is to provide a Faculty-wide innovative, patient centred, rural community based and educationally sound full year rural medical programme. A further aim is to encourage RMIP students to consider the rural medical workforce in their career planning.

Summary

Overall the feedback has indicated an exceptionally positive experience for most of the stakeholders involved. The RMIP management team can be confident that the course they are offering provides students an educational experience at least equal to that of their campus-based peers. There are however refinements that would improve certain aspects, for example assessment. A communication strategy including appropriate documentation will ensure that successive staff will be able to maximise engagement with the programme. This should be supported by appropriate and consistent administrative support.

Commendations

1. Students get a good educational experience
2. The feedback and enthusiasm for the programme overall from stakeholders at all levels was consistently positive
3. Students receive a good patient centred comprehensive experience of medicine
4. The programme provides an environment where students feel ‘known’ and consistently valued by colleagues and patients
5. The development of self-directed learning skills is an explicit focus of the programme
6. The programme developed the skills required to work as part of a health care team
7. The year builds the students’ confidence
8. Close contact with teachers is a definite strength
9. The teaching and administrative team members are effective in their roles
10. The year provides a positive overall impression of working in a rural community
11. RMIP management are already aware of and are addressing some of the issues raised during the review, including the need for longitudinal monitoring of the programme.
**Recommendations**

There were some areas where the review panel felt that improvements could be made.

**Assessment within RMIP**
The following should be attended to:
1. Clear and detailed documentation of assessments is required
2. The volume of assessment is excessive and should be reduced
3. The summation of assessments does not represent current best practice in the context of a criterion based distinction/pass/fail system
4. Forms of assessment should be reviewed and informed by the outcomes database
5. There is a perceived imbalance between formative (insufficient) and summative (too much) assessment which should be addressed
6. Quality assurance should be built into the assessment process and brought into alignment with faculty requirements
7. A robust system of benchmarking marking should be developed.

**Communication strategy**
Overall there is a need to develop and implement clear documentation and communication pathways. Particular areas to note are:
1. Staff briefing
2. Course administration
3. Course materials
4. Timely communications
5. Use of Learning Management System (LMS)/IT

**Administrative support**
1. Current administrative support in the regional centres needs to be formalised
2. More detailed job roles.descriptions should be developed using University Formats
3. The amount of administrative support should be increased
4. Finance streams and remuneration systems should be standardised and made transparent.

**Development and utilisation of resources**
Greater attention needs to be paid to the development and/or utilisation of electronic resources in all aspects of the course (administrative and educationally)

**Course alignment and content issues**
1. Support for students from centres where modules occur at different times in the curriculum (psychological medicine and public health) needs to be reviewed to ensure these students achieve the agreed faculty learning outcomes
2. Evidence Based Practice should be clearly identified in the programme
3. Access for RMIP students to resources available to campus-based students should be clarified
4. There needs to be greater consistency across the centres around administrative and learning support for students.
1. Introduction

The review panel considered three questions in framing this review.
1. Is the programme an appropriate and acceptable educational experience?
2. Does the programme represent good value for money?
3. Does the programme fulfil the aims for which it is designed, specifically the impact on the rural workforce?

This internal informal review focused primarily on the educational experience.

The review felt ‘value for money’ to be a complex interrelated issue beyond the scope of this review. However the panel strongly recommends that the Faculty initiates an analysis of the course’s financial viability.

This review also does not consider whether the programme fulfils all the aims for which it was designed, specifically the intent to attract graduates into future rural medical appointments. The programme’s steering committee realises the need for longitudinal tracking over the next decade, and how this might be undertaken; Faculty/Department is encouraged to consider how best to support the research required.

It is also noted that the review is not a comparison with other campus based Year 5 experiences and that some comments made may be attributed equally to the general issues of curriculum management in the campus based courses.

1.1 Background
The primary educational aim of RMIP is to provide a Faculty-wide innovative, patient centred, rural community based and educationally sound full year rural medical course. A further aim is to encourage RMIP students to join the rural medical workforce.

The Rural Medical Immersion Programme commenced in 2007 with the placement of six students based in Queenstown (3) and Greymouth (3). In 2008 the programme was expanded to 12 students with the inclusion of Balclutha and Dannevirke. In 2009 the course further expanded to 20 students with the inclusion of Blenheim and Masterton.

1.2 Methodology
The commendations and recommendations made by the review panel were informed by:
- RMIP Documentation (mainly the student handbook and the RIMP web site)
- Staff feedback through one-to-one interviews with the regional coordinators, a survey sent to clinical teachers and a letter requesting input of University based tertiary teachers
- Student feedback gained through focus groups.

The report will be submitted to the RMIP management group, Department of General Practice before tabling at the Faculty Curriculum Committee, after which it will be released to interested parties, including students.
2 **Commendations**

2.1 **Students get a good educational experience.**
The educational outcomes are the same or better than those for campus based students based on the mean results of fifth year examinations. It is not possible at this stage to account for selection bias, but the evidence of assessment supports confidence that the academic experience of RMIP students is at least equivalent and in some cases possibly superior to the traditional course (see Appendix 1).

2.2 **The feedback and enthusiasm for the programme overall from stakeholders at all levels was consistently positive.**
Students and teachers feel they are gaining experiences that other students don’t get and report positively about their decision to do the RMIP year. Teachers in the regional centres are positive about both the programme and their involvement in it. Clinical teachers feel they benefit professionally as well as personally from being involved in the RMIP.

2.3 **Students report a good patient centred comprehensive experience of medicine.**
There is a high level of clinical exposure reported, with more ‘hands on’ involvement and a high level of practical skills acquisition for students when compared to Year 4. Students feel the constant reinforcement of knowledge with the volume of experience provided in the clinical setting is a valuable part of the learning experience. Less competition among students for this hands-on time with patients is seen as an important aspect of facilitating this experience, as well as the sense that, patients were more responsive to student engagement than in previous years.

2.4 **The programme provides an environment where students feel ’known’ and consistently valued by colleagues and patients.**
Students are welcomed as contributing members of the health care team by both colleagues and by patients within the community in a way they don’t perceive in Year 4. They felt welcomed and valued as a contributing member of the team, rather than a burden: 
*’You’re not just the notes girl or the folder guy’*

2.5 **Close contact with teachers is a strength**
The programme’s achievement of its aim of providing close contact with teachers is a strength. The students compare the motivation and enthusiasm of teachers favourably with Year 4 where the quality of the experience and degree of contact with clinical teachers was described as more variable.

2.6 **The development of self-directed learning skills is an explicit focus of the programme.**
The focus on self-directed learning is a strength and the flexibility in time and focus on self-directed learning is valued by students. Students noted they feel well prepared with the lifelong learning skills that are required of a doctor as a result. The ability for students to identify and pursue their personal gaps is an identified strength. Students feel that with the combination of this self-directed approach and the high level of skills acquisition and patient contact that they will be better prepared than they would otherwise be for their early career years, and that it will smooth the transition to their junior doctor years.

2.7 **The teaching and administrative team members are effective in their roles.**
The feedback about RMIP staff was very positive from students. Students feel they are well supported, and that staff are very responsive to any issues that arise. The Course Director and administrator are seen as being extremely effective in their roles and this is a factor
important to the success of the programme. The regional co-ordinators are also viewed as being very effective as well as providing good role models. There appears to be a high level of responsiveness to any negative issues at all levels.

2.8 The programme developed the skills required to work as part of a health care team. Students report learning to work in a team and have positive experiences of collegiality and the skills required. They feel well positioned to contribute as a useful team member in their junior doctor years, as well as more aware of what other team members have to contribute to care.

2.9 The year builds the students’ confidence. After initial anxieties about ‘keeping up’ with campus-based students, students communicate a real sense of confidence in their level of practical ability to interact with patients as a result of their exposure during the year. There is a sense of enthusiasm for their future career. Their understanding of the role and those of allied health professionals is increased and students comment that they feel they will be able to use these services and professionals more effectively as a result of their exposure.

2.10 The year provides a positive overall impression of working in a rural community and/or smaller centre. Early indications are that RMIP students preferences for a rural workforce setting rank more highly than they would have previously. Students indicate that a rural or smaller centre placement for PGY years is more likely. It is too early to say whether this will be realised in changes in workforce yet as early students are not far enough down their career pathway. The panel commends RMIP management’s intention to put in place a formal longitudinal research framework to ascertain, considering itself to be an important part of continuous evaluation of the programme.

3 Recommendations

3.1 Recommendations to RMIP Management Team

It is timely now to focus on evaluating, developing and streamlining other aspects of the programme, bringing to bear the strengths of the new team to consolidate these. The following recommendations should be noted in the context of a maturing course and a background of curriculum change within the Faculty.

3.1.1 Assessment within RMIP

3.1.1.2 Clear and detailed documentation of assessments is required.

Documentation around assessment was sometimes unclear and/or overly complicated. Standards and criteria should be readily available for all assessments. This includes providing University staff involved with more information about what they might be expected to contribute to the programme.

3.1.1.3 The volume of assessment is excessive and should be reduced.

The review group were aware that that initial over assessment was built into the programme to reassure sceptics about quality, but the evidence clearly suggests the RMIP course provides the students with an educational experience at least comparable with the campus based students.
Students were consistent in their view that assessments were getting in the way of learning. The number of short cases was felt to be excessive and the long case a lot of work for little gain.

We recommend that the number of short cases is reduced to perhaps 5 in the first quarter and the long case is reviewed to ensure it adds to the learning experience.

3.1.1.4 The summation of assessments does not represent current best practice in the context of a criterion based distinction/pass/fail system.

An example was attributing a mark for on-call attendance; this would more appropriately be a terms requirement. The assessment system should be brought into line with Faculty criterion based policy.

3.1.1.5 Forms of assessment should be reviewed and informed by the outcomes database.

Consideration should be given to aligning the MCQs with EMCOs. We recommend close liaison with the Faculty Assessment Sub Committee to inform all assessment practice within the programme.

It was clear that students were unable to achieve some aspects of the log book requirements and that its summative aspect has the potential to influence its reliability.

The policy and practice of students selecting staff to complete the Teacher Evaluation forms should be reconsidered to include a broader range of opinions (e.g. 360% appraisal).

3.1.1.6 There is a perceived imbalance between formative (insufficient) and summative (too much) assessment which should be addressed.

University guidelines suggest “The formative (learning) functions of assessment will be given at least as much emphasis as the summative (grading and selection) functions” (Senate Policy on Assessment of Student Performance). The assessment blueprint for the programme should be reviewed to ensure an appropriate balance between these functions of assessment and to ensure that learning is supported. It is acknowledged that the close relationship between RMIP students and teachers will enhance the ongoing informal formative assessment.

The use of a summative log book should be reconsidered. It could be developed as a terms requirement concentrating on core skills in which students are required to demonstrate competence (as per Dunedin School of Medicine clinical skills log book). Other possibilities include developing a reflective portfolio. Whatever approach is taken it is essential that the outcomes are verifiable and the process valued by the students.

3.1.1.7 Quality assurance should be built into the assessment process and brought into alignment with faculty requirements.

Issues of inaccurate recording of assessments were noted. The process for recording assessment results and their management were unclear. We recommend that RMIP explore the possibilities of using the FRED database. In the long term the assessment data and student progress records should form part of this faculty database. Again, closer links with FASC would be helpful.

3.1.1.8 A robust system of benchmarking marking should be developed.

Whilst the review group were confident that the RMIP students are gaining a comparable educational experience it is important that there is a robust system to benchmark their
performance with the other year 5 students. The current system of involving staff from the wider campus has limitations. These are partly due to communication, funding and workload issues. Improved systems to involve specialist staff need to be developed, perhaps through a system of ‘external’ (i.e. campus based) examiners and closer links with FASC.

Consideration should be made regarding whether RMIP feels the need to benchmark (including answers) from other campuses or have sufficient experience and confidence to consider RMIP as a stand-alone programme.

While some School-based module convenors were concerned about their input and involvement, and also about the quality of the learning, comments were not consistent. We recommend that RMIP liaises directly with the staff who raised concerns.

3.1.2 Communication strategy
Overall there is a need to develop and implement clear documentation and communication pathways. Particular areas to note are:

3.1.2.1 Staff briefing
There was clear evidence of the ‘Chinese whispers’ effect. Staff briefed by those with more contact with the programme generally had a better, but not necessarily sufficient, understanding of the programme. The need for more information grew the further down the chain the staff member was. Students were often the best source of course information. The information needed was mainly around the learning outcomes and student assessment. Widely available, hard and electronic versions of the relevant material would substantially address this issue.

3.1.2.2 Course administration (e.g. contact lists, who does what):
Incomplete and inaccurate contact lists caused difficulties for the review team during the information gathering part of this review. This problem is not confined to RMIP as all of the ALM Schools have similar difficulties. The review team is aware of the difficulties in maintaining an up-to-date contact list and the course administrator is to be commended on the efforts being taken to address this issue. The contact list should be widely available via the chosen learning management system. Practical solutions have been identified (for instance, using invoicing, teacher reports, and students to help update lists of clinical teachers).

Roles and responsibilities of staff involved with the RMIP course need to be clearly identified and documented (an organisational chart would be helpful). Governance of the course needs to be clarified and documented.

3.1.2.3 Course materials should be readily available to all involved through clearly defined channels in hard copy and electronically.

The course handbook is a useful resource but needs to be supported by additional material in both hard copy and electronic format and made widely available. We recommend that a comprehensive course compendium is developed to include all material (outcomes, assessments, resources, contacts, structures etc). This should be held centrally as the definitive source of all course information and would ensure smooth transition through any major staff or organisational changes. It should contain all course information including expanded information from briefings: the housekeeping section of the manual is extremely concise when compared with similar sections of the campus handbooks (eg student welfare, evaluation).
3.1.2.4 **Timely communications** with all involved. Staff external to the course commented on late requests for input (e.g. marking assignments/cases, contributing to residential weeks). This was not a universal problem but one which needs to be addressed through early planning and communication (for instance, students could advise assessment co-ordinator of case topics well in advance so appropriate liaison with marking departments can be undertaken). RMIP will have little control over intra-school or intra-department communications but a well-publicised, readily accessible e-calendar should be considered.

3.1.2.5 **Planned research** should be communicated to course staff for future involvement and development. Staff engaged with the RMIP course indicated that research into the course and its impact should be undertaken. Discussion with course organisers indicated that such research was being planned. This intention should be communicated to staff involved with the programme and others who may offer support and expertise.

3.1.2.6 **Use of Learning Management System/IT**: The review team acknowledge that there are technical difficulties outside the influence of the RMIP organisers that make the use of some technologies more difficult in rural locations (e.g. poor broadband coverage in Alexandra, West Coast). The value of the Mobile Surgical Services in supporting video-conferencing facilities was noted. The overall use of the available technology in both an administrative and e-learning context was weak. Little use is made of the chosen learning management system (Moodle). The RMIP website has a very professional look but provides limited information. Considering the diverse geographical nature of the course it is a prime area to take a lead in building on and developing e-learning as part of a blended approach to the student experience. More use should be made of Otago e-learning resources including the Senior Lecturer e-Learning, library staff, HEDC/Education Media and the Distance Learning Office.

3.1.3 **Administrative support**

3.1.3.1 **Current administrative support needs to be formalised**
It was clear that coordination and administrative support have grown in a relatively ad hoc way, particularly in the regional centres. In some cases, this is practical and others philosophical, but the result is that students in some centres spend more time than others on performing administrative/organisational tasks rather than on clinical or self-directed learning or assessment tasks. Their perceived lack of authority to perform these tasks also affects their value. Roles, funding, availability and reporting structures vary widely. A more focused and formalised approach needs to be taken to establish what administrative support is needed and how it can be best provided. Clearly documented reporting structures are required and greater central guidance/control is recommended. It is noted that RMIP management are in the process of addressing this issue.

3.1.3.2 **More detailed job roles/descriptions should be developed**
Part of the review of administrative support must include a co-ordinated approach to the development of job roles and descriptions. These should be within official University guidelines.

3.1.3.3 **The amount of administrative support should be increased**
The RMIP course is complex with a heavy reliance on good, timely communication and interpersonal relationships. The current administrative support, whilst of good quality, is
quantitatively insufficient for the volume of work required. This should be increased to ensure a more effective use of staff time and enhance communication and organisation.

3.1.3.4 Finance streams and remuneration systems should be standardised and made transparent.
Whilst the financing of the course was not a focus of the review team it was apparent that this was an area that required consolidation and formalisation.

3.1.4 Development and utilisation of resources.

Greater attention needs to be paid to the development and/or utilisation of electronic resources in all aspects of the course (administrative and educationally)
The need to utilise e-learning is noted in 3.1.2.6 above. The review team felt that the management, administration and profile of the course could be enhanced by more effective use of electronic media.

3.1.5 Course alignment and content issues

3.1.5.1 Support for students from centres where modules occur at different times in the curriculum needs to be reviewed to ensure these students achieve the agreed faculty learning outcomes.
Because of the different curricula in the ALM schools concern was raised that students who had not been exposed to topics in year 4 (primarily Psychological Medicine and Public Health) may be disadvantaged. Our review found little evidence that the students were indeed disadvantaged but the potential and perception remains. RMIP must ensure that the agreed outcomes for these topics are achieved by the students. Close liaison with discipline specialists may be required to allay the non-achievement fears. Good documentation of student achievement will help to allay those concerns held by some areas that RMIP students are not performing as well as the rest of the year.

3.1.5.2 Evidence Based Practice should be more clearly identified in the programme.
There was little evidence of this important area in the RMIP course. This is not to say the students do not see EBM in practice, rather that there is no documentation of or focus on it.
We recommend that RMIP staff work with other faculty staff to enhance this aspect of the course. Clear outcomes and links to relevant assessments should be documented.

3.1.5.3 Access to resources available to campus-based students
Students were concerned that the end of year assessment might include material that is only able to be covered on campus, and in many cases had the expectation that any course materials produced for campus students would also be available to them for use in self-directed study. While they can download (albeit slowly in some cases) anything posted on Blackboard/Moodle, not all material is posted.

The cost of providing hard copies of course material was an issue to some staff; there is also a danger of overload in providing the RMIP students with both their own specific course materials and that from their home campus. This largely an issue of expectation and reassurance; students should know that the RMIP specific materials are developed to be equivalent to on-campus material, as long as they have access to practice assessment they should be aware of what will be covered.
3.2  Recommendations to Faculty

While some of these recommendations would require involvement by Faculty to implement, the panel also felt that there were recommendations that could not be primarily addressed by the RMIP management team and were primarily Faculty’s responsibility.

3.2.1  Financial Viability
The panel strongly recommends that the Faculty initiates an analysis of the course’s financial viability. This should also include the resultant financial impact on other modules unable to use the learning environment, eg. Rural attachment, DSM.

3.2.2  Conflict between RMIP and campus-based students in rural clinical environments
Cognizance needs to be taken of other students based in the same clinical environment competing both for patient and supervisor time. Student placements in some instances may need better coordination and communication with other module/clinical attachments.
4 Appendices
The following sections summarise the material garnered from the various surveys and interviews carried out to inform this report. The full data set is available from the review team.

4.1 Student feedback

Objective of Feedback:
To inform the RIMP course review by seeking student feedback on strengths and weaknesses of the RIMP on a selected range of specific issues

Methods:
Groups and individual students were interviewed by Dr Tony Barrett (Medical Education Adviser, ELM) from mid-July – early 2011 August with notes and additional input from Karin Warnaar (Project Officer, Faculty Education Unit). There were six video interviews, one audio interview one phone interview and one face to face interview.

Results Summary:
20 students participated (100%)
Results are summarised by question with a brief overall view at the end of the document.

1 What were your expectations of RMIP and how were they formed, and have they been met?
There are three elements within this question:

1.1 Expectations were:
- A high level of clinical exposure with more ‘hands on’ involvement and a high level of practical skills acquisition as a result.

Less competition for this hands on time with patients from other students, and as part of this, patients who were more responsive to student engagement.

An environment where they would feel ‘known’ by both colleagues as part of the team and by patients within the community and would have closer contact with teachers.

- There were some negative expectations – or worries – regarding preparation for exams and the detailed ‘academic’ requirements for the year.

1.2 Expectations were formed by:
- Expectations were formed largely by feedback from previous students and presentations – there were few comments on this.

1.3 Were expectations met?
- Expectations were almost universally met
- Expectations were not met for some in terms of contact with secondary care consultants/specialists
2 What do you think of the RMIP placement thus far?
Expectations listed above were generally felt to be exceeded with much superlative use! (‘Awesome,’ ‘stoked’, ‘fantastic’, ‘love it’) Comments indicated students felt universally pleased to have done the RIMP.

Students felt it was a much better experience than 4th year, that it was flexible and well organised – and that a single co-ordinator was important in this.

Students also commented:
- They felt welcomed and valued as a contributing member of the team ‘you’re not just the notes girl or the folder guy’
- Being able to view the continuity of care and longitudinal care was felt to be a very valuable aspect of the year
- The workload was felt to be too heavy
- The teaching is good but students commented the opportunity for peer learning is more limited as they are not experiencing situations together

3 How well is the course working (e.g. access to resources, appropriate coverage/reinforcement of previous material)?
- The question around access to resources elicited some frustrations where access has not met expectations with themes generally around not enough material / out of date blackboard with some extra difficulties because of the Christchurch earthquake hinted at
- There was a desire expressed for more hard copy resources – that downloading and printing was time consuming and difficult in some centres with poor internet access – in contrast some hard copy resources were not felt to be of great value (e.g. UOW workbook)
- Students felt access all the course material provided to mainstream students at the main centres was problematic
- Some centres had difficulty accessing appropriate areas compared to others (e.g. Queenstown – O and G and paeds were highlighted as difficulties)
- the curricula being out of step at the different centres, and the RIMP being Dunedin curriculum driven was a major issue in terms of both overlap and gaps in appropriate coverage
- The students felt unclear about the year objectives and stated throughout the focus group questions that the log books do not provide an adequate framework and need improving
- Students felt the course built on 4th year but made year 2 and 3 seem less relevant. The year works well to embed learning – it is felt the clinical experiences constantly reinforce knowledge
- The Moodle and immersion weeks were felt to be very useful

4 What are the best features of your experience?
Many ‘best features’ were highlighted in contrast to urban placements – both previous experience and the experience of their urban classmates.

The relationships were very important – with staff and with patients and the view of health care that comes with the longitudinal immersion in a community were felt to be a hugely valuable and unique part of the RIMP, and feeling ‘known’ by both added to the sense of feeling valued overall. Other important features were:
• The enthusiasm and collegiality of staff – being taught by people who really want to teach compared to hospital where its ‘hit and miss’
• Students felt valued in the team – that they were helping rather than being seen as a hindrance
• A level of hands on experience that builds self-confidence – this was a recurrent theme through other questions
• The ability to learn about and pursue particular areas of weakness

5 What effects this will have on your future practice as a doctor?
Students felt they were getting skills that would be useful to the teams they work in future years – felt they would be more useful in this regard as a result of the RIMP year. They also felt better prepared both with the range of skills they now have and in their ability to work in a team – to know what this involves and that they were acquiring the skills required for the job of being a doctor sooner.

A unique asset for future practice was felt to be knowledge of the role of allied health professionals and services that would allow them to use and integrate them into care more effectively

The acquisition of the self-directed learning skills necessary for the lifelong learning required to be a good doctor was identified as a key effect of the RIMP on their future practice.

6 What do you think could be improved?
Some said little – a list of suggestions that emerged includes:
• Timetabling and organisation to cover requirements could be improved – there was a sense that this varies by centre.
• There was a disjointed feeling at some centres as they jumped between seemingly unconnected areas in the same day – there were no specific suggestions on how to address this.
• The overlap and disconnection in curricula between centres and the tension and difficulties this creates for students needs sorting out - this was a recurrent theme.
• Students feel the amount of assessment needs reducing – it is felt that this diminished rather than enhanced the learning experience significantly and that there may be an on flow effect from the pressure teachers feel for students in the RIMP to do well and be seen to do well.

More specific suggestions were:
• Short cases (frequent comments). The cases themselves were not so much the problem – rather it was the volume – there were felt to be too many. They appeared to be a major contributor to the feeling that the workload was too great and was stressful / resulted in a poor work/ life balance for students. There seemed to be a difference between the requirements and the markers expectations.
• Essay on how patients are people not the best way to engage with hoe patients experience /are affected by illness
• Long case – felt to be a ‘relic’ of hospital based assessment by some – more than one comment that the large majority of the learning came from spending the 2-3 hours with the patients but the 20 hours writing up was felt to be very disproportionate to the degree of extra learning value that was attached to this part of the exercise. There was a suggestion that a viva would provide better value as well as interactive feedback for the student.
In contrast to these comments the MCQs OSCEs received frequent positive comment

Inevitably exposure mix varied according to the centre as did organisation. Marlborough was felt to be less well prepared for group tuts and despite the enthusiasm of the co-ordinator things ‘went awry’ for students linked with the Marlborough Regional Coordinator – partly because he was working as a locum out of Blenheim it was suggested.

- More use of ViPR was suggested to link to tuts and lectures
- More specialists teaching was a theme through many questions – it appears that this represents a request for more detailed teaching more than who is teaching
- More help with the administrative aspects/ organisation aspects of the course - students have some difficulty getting responses from consultants for example where they feel an administrator might have more luck. Organising contact with consultants in Queenstown appeared to be especially problematic. It seemed that the degree of organisation varied by region as would be expected – in some the coordinators organised and planned tuts in advance while in other students were left to organise and finding a time that suited and a person to teach was problematic at times.

7 What is your relationship like with...?
Specific roles weren’t able to be discerned form the feedback. Particular mention for positive comments were for the Regional Coordinators in Clutha and Taararua. Generally there were positive comments on relationships all around – it was felt that response was rapid when serious issues came up and that students never felt abandoned.

There were some localised difficulties inevitably – some consultants clearly were not on side and allusions were made to some kind of awkwardness with previous students. There were also some local difficulties with some midwives given as an example. Difficulties with direct contact with specialists in some areas as already mentioned.

8 What aspects of these relationships do you feel could be improved?
The Marlborough Regional Coordinator came up more than once in suggestions through groups– felt aspects of planning / organisation could be improved.

In some areas working space was an issue.

It was felt there was a push back / resistance sometimes about feedback, especially with regard to assessments.

9 What do you think of both the assessments within RMIP and also how prepared you feel you will be for the end of year 5 assessment.

See previous negative comments and suggestions regarding the short and long cases in particular, as well as the positive comments on OSCEs and MCQs as assessments. Students felt well prepared for MCQs and OSCEs for 5th year but less certain of preparation for examination of detailed knowledge – pathology and other speciality areas.

There were several comments that the forms for doctors to assess students didn’t match the experience and that some doctors have seen them enough to complete the form or were puzzled by how to complete it

There were comments that prescriptions and referrals didn’t reflect experience – referrals were mostly from GP exposure which could be limited and many didn’t see the required
number in a quarter. It was suggested the number is reduced to reflect the reality of exposure.

Overall it was felt the time burden of assessment was particularly large and there were opportunity costs in terms of real learning for what students perceived to be ‘hoop jumping’. Students didn’t feel assessment helped them with perceived potential gaps in detailed knowledge.

Some assessments – the log book and the self-evaluation as a summative (rather than formative) assessment were felt to encourage a positive response bias in an unhelpful way.

There were several comments that the log book was disconnected from the programme and needed refining – there were many experiences not covered by the logbook and many in the log book that were never experienced (and not likely to be). “Portfolios” were suggested by the focus group facilitator and this seemed well received. There was a desire to understand how the assessments linked with the end of year assessment.

Assessment were felt to be a good way to tease out gaps in knowledge during the year. One comment was made that the assessments or skill set seemed to reflect what was valued in an urban hospital setting but there was a skill set that came with a rural health care setting that was just a valuable.

Generally students felt well prepared for the 5th year exams and valued the time off in 4th quarter for revision.

10 How is the workload?
Many comments that it was too great – interfered with learning and the opportunity to experience the benefits of living in a rural setting – the ‘life’ part of the work life balance.

There were a number of comments that the workload from the volume of assessments and assignments interfered with the ability to engage in self-directed learning.

11 How has your experience of RMIP affected the likelihood of your including rural practice in your future medical career?
Comments suggested a rural aspect to career planning was higher up the priority list and considered more of an option than it had been – especially with regard to rural placements in RMO years.

Not clear whether there was increased interest in rural general practice.

It also highlighted the cons of rural communities for some students.

Other
Own medical care – ‘bit frustrating, we don’t have a GP here, don’t know what I would do if I got sick, would be good to have that formalised’.

In summary
• The feedback was overwhelmingly positive.
• There were some specific areas that could be valuably addressed – in particular assessment issues, resource access and some unevenness in experience and organisation between different areas. Addressing these should address the workload issues that were raised.
• Students felt it is a good educational experience and prepares them to be well ahead of their colleagues for the work years ahead.
• It is not clear whether it will increase rural workforce – there is a sense that it increases thought about this option as a higher priority than before.
4.2 Appendix 4.2 RMIP Staff Feedback

Background
All the Regional Coordinators (RCs) were interviewed, predominantly using Skype. These interviews were not recorded but field notes made. In addition the Course Director (CD), Course Administrator, Assessment Coordinator, Assessment Administrator and the Staff Development coordinator were interviewed.

The basic structure adopted included: were they (RCs) enjoying the RMIP course, what were the positive features of the course and what were the areas for improvement. Assessment and course administrators were asked specific questions about assessment.

Positive aspects
- All the staff members enjoyed the course and usually the students on the course. There was a huge commitment to the underlying philosophy and the sense of a belonging. There was a great sense of enthusiasm and camaraderie evident between the staff.
- The leadership management from the CD and Administrator were well received as were the regular meeting with other RCs.
- The role of the CD in consolidating and refinement of the course was acknowledged.
- Input from the staff development coordinator was well received.
- Assessment was felt to be well organised.
- Clinical staff were generally felt to be responsive to the needs of the students and in certain cases where personality conflicts arose between a student and staff these were able to be resolved.
- Involvement in the end of year summative OSCE was appreciated and helped in reassuring the quality of the student produced and to offer a crude benchmark.
- The residential weeks appeared worthwhile and enjoyable from the RCs’ perspective.

Areas for consideration
Within the interviews the areas of concerns were minor when the overall interview was considered. Areas for consideration varied between regional coordinators (RC) and were influenced to a degree by the period the RC had been in post. The following is a brief summary of the main themes.

- **Transparency of learning.** A concern was the transparency of the learning required by the students – what depth was required was sometimes unclear to staff. This may be due in part to the embryonic nature of the course.
- **Handovers from old to new RCs.** This handover could be slightly problematic as some historically information is held personally rather than on paper.
- **Regular RC and CD meeting.** The regular meetings between the RCs and Course Director could be more efficiently chaired, although the informal atmosphere was appreciated.
- **Student competition for learning.** In a few areas there were some clashes between students on different attachments/modules/year (more than could be accommodated). Cognizance needs to be taken of other students based in the same clinical environment competing both for patient and supervisor time. Student placements in some instances may need better coordination and communication with other module/clinical attachments.
- **Role demands.** The joint role of the CD and RD can pose difficulties due to time demands. There may also be conflicts of interest although these were not apparent.
• **Access to clinical material.** This was generally felt to be good and the balance between GP based activity and hospital based activity was felt to be appropriately devised under the direction of the RC.

• **Assessment**
  - A minor concern was a **conflict of interest** of a RC playing a role in quality assurance of the OSCE and MCQ. In discussion with the Chair of the Faculty Assessment Sub-Committee this was not felt to be an issue. It is hard however for the assessment coordinator to get checks on validation from specialist.
  - There appeared to be little in the way of communication between other University staff and the assessment coordinator to ensure standards. Considering the time frame, greater involvement by other staff may be hazardous to ensure the assessments are available in an appropriate time scale. An issue with the MCQs is that many central University staff do not seem to want to part with them.
  - **Benchmarking and criteria.** Some RCs indicate that the criteria for some assessment methods could be more clearly articulated. A session on sharing views about the marking of the cases may be advantageous.
  - Some RCs felt that there was **too much summative assessment**.
  - **Quality assurance.** Some mistakes had been noted in student in-course assessment results.

• **Administration**
  - There are a number of core administrative task that may be beyond the capacity of one person. A larger core nucleus of administration staff in a central location may be beneficial to share administrative tasks.
  - Contemporary lists of staff and process and policy need to be more clearly articulated. This has arisen due to the limited access to material from the previous incumbent and will resolve given time.

• **Critical mass of students for learning and living arrangement.** Reference was made, in some sites, for the necessity of a specific number of students in the learning environment in order to maximize learning. One student in one learning environment was felt to be isolating and potentially difficult for a student to cope with. The provision of accommodation was alluded to where the students living together was beneficial there was also acknowledgement that this may not always be appropriate.

• **Future educational vision/innovation and research.** A couple of RCs identified that they were unsure whether the current CD would be able to offer leadership in educational innovation and research. The research element was currently felt to be lacking and needed to be bolstered.
Appendix 4.3 Staff Surveys: RMIP Clinical staff & Campus-based Staff

Two main surveys were carried out. RMIP clinical staff (i.e. those in the rural centres) were given the opportunity to complete an on-line survey. Campus based staff were contacted by e-mail and could respond by e-mail or via an on-line survey.

Response rates were low for both groups.

4.3.1 RMIP Clinical staff responding constituted

Staff introduced to the programme by the course director or administrator generally felt they had a better grasp of the details than those who relied on local staff to brief them. Most staff had access to written information. Areas where they required more information were ‘what the students needed to learn’ and assessment. A better grasp of the RMIP and ALM curricula would be helpful.

The overall impact on practice was very positive with students adding value and helping create a stimulating environment.

4.3.2 RMIP Campus staff provided 17 responses from 65 requests; this represents a very limited number of departments. Only 13 of the comments were substantive. The low response rate seems likely to be largely due to an inaccurate database.

Although responses varied widely a number of key themes emerged. Communication is an issue in some areas, more noticeably for the northern schools. Late requests for staff to mark student assessments, organisation of the residential weeks and general lack of interaction between the RMIP and departmental staff are the main issues.

Public Health and Psychological Medicine pose particular problems due to their lack of alignment in the curriculum. Public Health suggests that the current arrangements are inadequate for the UOC students. Psychological Medicine UOW provided the most comment and express concern on the knowledge base of the students and lack of exposure to severe mental illness.

The knowledge base of the students elicited comments varying from excellent to inadequate. Often, though not always, the comments appear to be based on small samples of work marked and made in comparison to students on the traditional course.

Some concern is expressed regarding a perceived gap between RMIP and the ALM programme and some ensuing ‘resentment’.

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</tr>
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<td>8</td>
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<td>Wairarapa</td>
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<table>
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<th>Table 2. Staff group</th>
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<tr>
<td>Administrator</td>
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</table>
4.3.3  RMIP Clinical staff input via SurveyMonkey

Q1-3 Location, role, length of involvement
See tables 1 & 2 above for location and role. Greymouth & South Westland (14) and Wairarapa (13) provided the most respondents. 73% (33) of respondents were doctors; 11% (5) administrators and 9% (4) nurses. 80% had been involved since at least 2009.

Q4 how introduced to course
18 by practice or hospital colleagues
14 by course director &
17 by regional co-ordinator.
Those introduced by the course director or regional co-ordinator were well briefed (always/usually). Those who relied on briefings from colleagues varied from ‘always’ to ‘not’ with a good spread across the range. See Chart 1.

Q5 How informed are you of...
Most (64%) are reasonably aware of student involvement in the practice but 27% needed more information. 53% felt they were reasonably informed about what the students needed to learn but 20% felt they were not sufficiently informed. 40% felt they had sufficient information about the student assessments whilst 26% had insufficient information. This question links closely with Q4 regarding the briefing of staff. Local briefings seem to be less effective in some areas.

Chart 1. Who RMIP clinical staff receive their information from and its effectiveness.

Q6 How advised about programme & assessment?
The doctors and administrators tend to be briefed by the course director; most staff appear to have access to published information and the programme administrator. The largest single source of information tended to be the students.

Q7 Impact on practice
Overall positive impact, students add value and encourage reviewing practice. There is some impact on clinic time (takes a bit longer). Two nurses commented that the time issue impacts on their work and patient involvement. Initially issues with space but these seem to have been resolved.
Q8 Best aspects
Helps create a stimulating environment & encourages/enables staff to keep up with what is happening elsewhere (21 comments along these lines).

Q9 Changes needed
35 comments: Six relate directly to communications, four to organisation and expectations and three suggested locally based training sessions would appreciated. The main thrust is a need to have a better grasp of the curriculum (RMIP & MB ChB) and to understand what the different roles and expectations of staff and students are e.g. role of the practice nurse in student learning. The organisation comments seem to refer to internal (site based) organisation. One commented they need more O&G.

Q10 other issues
A few new topics were notes: Recruit those interested in GP; link more with regional base hospitals (e.g. presenting grand rounds); closer involvement with rural/practice nurses – use their skills; ‘As many as possible teachers should be doing the Teaching and Learning GENX 823 paper to help improve the overall standard of education and training on offer’. Mainly they were reiterations of previous topics e.g. improve communication regarding what is expected of the students.
4.3.3 RMIP Campus based staff comments from email request

We would value your comments on

- The level of communication with RMIP and how this is achieved: what works well, what could be improved?
- Your satisfaction with the alignment of outcomes between the traditional year 5 course and the RMIP course
- Your awareness/involvement in:
  1. assessment
  2. in the residential week

17 responses from 65 requests

There were a small number of responses representing a limited number of departments so the findings need to be viewed in that context. Respondents rarely gave direct answers to the questions asked but usually offered a related opinion. The themes of their comments are described.

Communications

Not surprisingly there were variations in experience. Staff based in Dunedin had the most positive view suggesting that communications were generally good and timely. The one response from UOC felt that communications had been poor. UOW had a mixed response. Two departments felt communications were good and two felt they were poor. Poor communication issues centre on timeliness and expectations. Examples are late organisation of programmes and requests to mark assignments at short notice.

“In my opinion the communication between us and RMIP has been rather poor and one never really knows when one might be called on to mark cases or what one be expected to provide during the RMIP week, as noted by Pete, this could be planned and co-ordinated at the beginning of the year”.

“Staff here therefore feel a disconnection with these students and extra work such as essay marking, sometimes in the past submitted with little notice and tight deadlines, has been seen as an unwarranted imposition and been met with resistance”.

Aligning of outcomes

The practice of involving GP and consultant expertise to give feedback was noted as good practice by one O&G department.

There are issues in Public Health as the UOW/DSM students have completed their Public Health module in 4\textsuperscript{th} year whilst it is in the 5\textsuperscript{th} year of the UOC programme. The difficulty here seems to be the delivery of the programme rather than the outcomes per se.

Psychological Medicine at UOW expresses concerns about the level of experience and knowledge base of the RMIP students, this based on the marking of case studies and taking part in the final residential week of the year. They suggest a need for closer liaison in identifying the ‘learning goals’ for psychological medicine, timely (early) planning and a closer working relationship between RMIP and local staff. NB students from UOC & UOW normally do psychological medicine in year 5, DSM in year 4.
The **knowledge base** of the RMIP students is commented on by many of the respondents.

- O&G: generally good with some gaps (based on assignment marking & teaching in the study weeks).
- Oncology: felt it was good (based on one marked case).
- UOW (Palmerston North): noted good clinical skills, self-sufficient students but with some knowledge gaps.
- Public Health: was a problem for the UOC students who had little time to catch up. This aspect needs substantially revising as it is not adequate in its present format.
- ENT: noted some misconceptions that needed correcting.
- Psychological Medicine (UOW): expressed grave concerns and felt it was difficult for the students to cover all the ground needed in a residential week. They did acknowledge that the students seemed to perform well as TIs. UOC and DSM had no concerns.

**Assessment/residential week**

Most staff were aware of the residential week but were split in their comments about its organisation. DSM staff had good notice and information. UOC staff felt there needed to be greater integration, more timely planning and closer liaison.

Most respondents were, or had been, involved in assessment marking (cases or assignments). Comments focus on the quality of the student work rather than the appropriateness of the assessment although UOW Psychological Medicine noted that some effort has been made to address the issue of over-assessment but at the expense of some departmental input.

**Other points noted**

Several respondents allude to resentment caused by late requests to mark student work. A lack of RMIP representation at key meetings (e.g. FCC) and lack of progress reports. The need for a clearer understanding of the RMIP curriculum.

**4.3.4 RMIP Campus staff input via SurveyMonkey**

Three respondents (one from each School) chose to use the survey form rather than respond directly. While they were able to do so anonymously, their responses clearly identified them.

**Noted** good communication, advanced notice helpful.

**Concern about**

- O&G knowledge/experience
- Alignment of PubH & psych an issue (but what?)
- Variable clinical supervision for both courses (RMIP & ALM)
- Didn’t seem to take the long core case seriously (sample of 1).
- Pushed to support RMIP with little support from own dept.

**Good aspects**

RMIP students have good patient exposure, are positive & well prepared.

**Key points from all campus-based respondents**

- Timeliness and adequacy of communication, particularly to the northern schools.
- Keeping the departmental staff informed of outcomes and their required input.
- Public health for UOC students.
• Psychological Medicine concerns (knowledge base and exposure to severe mental health problems).
• The perceived gap between RMIP and the ALM programme and ‘resentment’ noted.

Summary

Overall the feedback has indicated an exceptionally positive experience for most of the stakeholders involved. The RMIP management team need to be confident in the course they are offering and now consider refinements to improve certain aspects, for example assessment. A communication strategy including appropriate documentation will ensure that successive staff will be able to maximise engagement with the programme. This should be supported by appropriate and consistent administrative support.
Appendix 4.4 Assessment Data

RMIP Assessment
The following describes the information about the RMIP assessment and also a comparison of results between the RMIP and traditional students.

Summary
- Students perform as well in their end of year summative assessment when compared with traditional students. There may be a trend indicating concern regarding a lack of pathology knowledge.
- There is a huge array of assessment. Discussion needs to take place regarding whether the amount of assessment is excessive.
- The dominant use of grades/numbers to determine assessment needs consideration especially in respect to the log book.
- It is unclear what feedback is given to students and this will require further exploration (hopefully received by Tuesday).
- The criteria used to assess students specifically the short and long case is unclear.
- PASAFs are not utilised in RMIP – this needs discussion at FASC.
- The list of tasks re: the log book needs refining as data indicates some are difficult to achieve (article attached).
- Quality assurance issue with regard data collection.

RMIP Assessment information - supplied by course Administration
Please see page 17-34 of the RMIP Manual for more information.
There are 4 ‘Assessment’ days in the RMIP teaching year. Each Assessment has a different set of tasks. These tasks all include OSCEs and MCQs, as well as a mixture of short and long cases, as well as referral letters, the logbook etc.

Assessment Days
There are 4 Assessment Days in the year.
The Administration Assistant sends each centre a pack with:-
- OSCE information for the students, markers and simulated patients
- MCQs which are prepared by John Hillock (Assessment Coordinator) in advance
- Return envelope for the completed paperwork.

The pack is sent ahead of time so that the Regional Coordinators can get all preparations needed – i.e. equipment for the OSCEs, and markers.
All the students sit the MCQs at 5pm in their regions. These are either then collected in by the Regional Coordinators (RCs) and then marked, or peer marked – depends on how the coordinator chooses to do it.
The OSCEs are then run at 7pm. They are marked by a mixture of the Coordinators and other GPs that have been asked to act as markers.
The RCs and / or the Regional administrators then email the raw marks to the administration assistant as soon as possible. She puts them into the database. Meanwhile, the paperwork can be used as a teaching material for the students by the RC. This paperwork is then posted to the administration assistant, who scans each item. The paperwork is then sent to the Dunedin office for destruction.
As far as I know, there is no moderation of the OSCE marks.

Short Cases
Please see Pages 23 – 28 of the RMIP Manual for more information.
The students have a different number of short cases to complete in each quarter. These cases are written up by the student onto the case reporter PCCMCR: To access case marker go to:

http://dsm2.otago.ac.nz:8080/case_reporter/auth/login

username: pccmcr
password: rmipcasemarker2011

The cases are then marked out of 10, as per the marking grid on page 25 of the RMIP manual.

I believe that each of the RCs have a copy of this and use it to mark the cases.

The short cases are pair marked by the student’s local RC and the paired RC. For instance the RCs of Clutha and Marlborough mark their own and each other’s students. The RCs have their own logon details for the case reporter – which is just a database. Under each RC will be a list of students to mark. They then select a number from 1 -2 for each mark-able facet of the case. Some RCs use ½ marks, some don’t.

Branko looks across the marks of all the regions to compare how they are doing.

There is a sample short case for the students on page 26 of the manual.

### Long Cases

There are 2 Long Case Assessments in the year, one in the 2nd term and 1 in the 3rd term. These cases are marked by the RC (?) and a specialist from one of the schools of medicine. These are used as a benchmark to see how the students are doing.

Similarly to the short cases, they are marked on the PCCMCR database.

### Overall Notes

The amalgamation of marks at the end of each assessment ¼ takes about a week. We then Page 29 shows how each component of the Assessments are weighted in each term.

In addition the RMIP Assessments, the students also complete a Paediatrician Long case which they present over the ViPr to a marker from DSM Women’s and Children’s health. There is also an assessment to do with MiHi which is co-ordinated by Jane Marriner in Christchurch.

The students are also expected to complete a logbook of cases that they have seen. With the aim that they see most of a large range of cases by the end of the year. The logbook is marked in each assessment quarter.

There is an overall Marking Method on pages 30-34 of the Manual

### RURAL MEDICAL IMMERSION PROGRAMME - AWARDING OF POTENTIAL DISTINCTION

(Downloaded from the RMIP web site)

1. Each student will be considered for Potential Distinction at each of the four RMIP assessments.
2. Potential Distinctions will be granted in two categories FORMAL SUMMATIVE ASSESSMENT and PROFESSIONAL ATTITUDES.

### A. Professional Attitudes

- Student must be above expected performance in quarterly teacher’s reports in the interpersonal relationships and professional characteristic sections
- The student will have demonstrated continuous positive involvement in the programme at the teacher centre leading to recommendation for PD by the regional coordinator
• Achievement of very good or above for all patient satisfaction questionnaires in the final quarterly assessment
• There must be agreement between the regional coordinator and the programme director that it be recommended to the RMIP BOS that the student be granted Potential Distinction

B. Formal Summative Assessment
Potential Distinctions in clinical performance will be based on attainment of a specific mark or above, based on weighted scores for the following:
• MCQ 25
• OSCEs 25
• Logbook 10
• Referral Letters 3
• On Call Log 4
• Teachers Report 10
• Core Cases Report 10
• Presentations 3
• 100%

Note One
In second, third and fourth assessments, MCQs and OSCEs drop to 20 points each and 10 points are applied to examination and consultation video recordings.

Note Two
For the last assessment, the on call log, referral letters and prescriptions (10 marks) will be replaced by the patient satisfaction survey.
To achieve Potential Distinction the student will need to score:
  70% or above in assessment one
  75% or above in assessment two
  80% or above in assessment three
  85% or above in assessment four
Nominations for overall Potential Distinction to the Faculty Board will include the Four Potential Distinctions from the 5th year RMIP plus distinctions in fourth year.
Analysis of Assessment Data

Method
The data has been considered from the perspective of noting any significant differences between scores of the traditional students and the RMIP students in the end of year 5 examinations.

End of year 5 results
Table 1: Total Mean results over the 4 year periods

<table>
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<th>Group Statistics</th>
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<th>Std. Deviation</th>
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Over the 4 years the RMIP students for the OSCE and written papers have achieved a significantly higher score than the traditional students. Differences have been positively significantly better for the written component specifically in O&G, GP, Paeds and surgery. There is a trend for the RMIP students to perform worse in pathology.

By year
2007
Table 2: Year 2007 mean scores

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<th>Std. Deviation</th>
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No significant difference between the RMIP students and the traditional students in 2007 looking at mean scores.

2008

Table 3: Year 2008 mean scores
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* a. Year = 2008

In 2008 the RMIP scores for the OSCE and written papers have been significantly better than the traditional students. Differences have been positively significantly better for the written component specifically in Public health, psychiatry, O&G, Peads, GP, surgery, Medicine and pharmacology.

**2009**

**Table 4:** Year 2009 mean scores
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*Year = 2009

In year 2009 the RMIP scores for the written paper was significantly better than the traditional students. Differences were positively significantly better for the written component specifically in O&G, GP and surgery.

### 2010

**Table 5:** Year 2010 mean scores
## Group Statistics

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a. Year = 2010

No significant difference between the RMIP students and the traditional students in 2010 looking at mean scores.

The first year of the course, 2007, and last year, 2010, the students appeared to perform comparably well with their traditional peers. The 2008 and 2009 cohort performed significantly better than their traditional peers on a number of parameters.